Revised 8/21/2017

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

CLINICAL AND ANCILLARY SERVICES EXPANSION REQUEST

General Instructions

Submit the completed application to **Email:** DIDDProvider.Application@tn.gov

All questions and correspondence regarding clinical and ancillary services should be directed to:
Email: DIDDProvider.Application@tn.gov **or Phone:** (615) 532-6530

Please provide the following information:

_____
Date of Application Request Submitted

_____
Name of Organization

_____
Address

_____
City State Zip Code

_____ _____ _____
Telephone Number Fax Number E-Mail Address

1. Check the service(s) being requested and identify the region(s) the organization proposes to expand service (s) :

REQUESTED WAIVER SERVICE (S)	**REQUESTED REGION(S)**		
	WEST	**MIDDLE**	**EAST**
Occupational Therapy			
Occupational Therapy Assistive Technology			
Physical Therapy			
Physical Therapy Assistive Technology			
Speech-Language/Hearing			
Speech-Language/Hearing Assistive Technology			
Nutrition			
Nursing			
Dental			
Behavior Analyst Services			
Behavior Specialist Services			
Orientation and Mobility Services			
Specialized Medical Equipment & Supplies and Assistive Technology			
Environmental Accessibility Modifications			
Individual Transportation (only for providers of Orientation & Mobility Services			
Personal Emergency Response Systems			

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_____

Date Application Request Submitted

_____

Name of Organization

For the requested waiver service(s) in the above table (section 1), please submit the following information:.

1. The reason(s) for requesting to add the new services(s) and/or region(s) marked in section 1.
2. A revised organizational chart that is inclusive of the oversight of the new service(s) and/or regions(s).
3. Submit a brief description of the plan to provide the new services and/or provide services in the new region.
4. **Assuring Clinician Coverage:** Providers are responsible for assuring staff coverage for authorized services in accordance with the Provider Agreement and must have a back-up plan for extended clinician illnesses, leave, or vacations. Please submit your updated policy for assuring clinician coverage.

Printed Name of Authorized Representative _____

Signature _____

Title _____

Date _____